

Precision Muscle Recovery
Confidential Client Intake Form
Please be sure and answer ALL questions.

Name _____ Today's Date _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Height _____ Weight _____ Birth Date _____
Profession _____
Referred by _____
Physician's Name _____ Physician's Phone _____
Emergency Contact _____ Phone _____

Bodywork Experience

1. Have you had a professional massage before? Yes No
2. Have you had an orthopedic assessment or treatment session before? Yes No
3. What types of massage/bodywork have you had? _____

4. How long have you been receiving massage therapy/bodywork? _____
5. Frequency of treatments? _____
6. What are your goals for this treatment? _____

Current Health

7. Do you exercise regularly and/or participate in any sports? Yes No
If yes, which sports/how often? _____
8. Have you recently suffered an injury? Yes No
If yes, describe: _____

9. Have you had/have any areas of inflammation? Yes No
If yes, describe: _____
10. Are you currently under the care of a physician? Yes No
If yes, explain: _____
11. Have you had recent surgery? Yes No
If yes, explain: _____
12. Are you pregnant? Yes No
13. Are you very sensitive to touch or pressure? Yes No
14. Do you have cardiac or circulatory problems? Yes No
15. Do you suffer from back pain? Yes No
If yes, upper, mid, or lower back? _____
16. Do you have any tension or soreness in a specific area? Yes No
If yes, please specify: _____

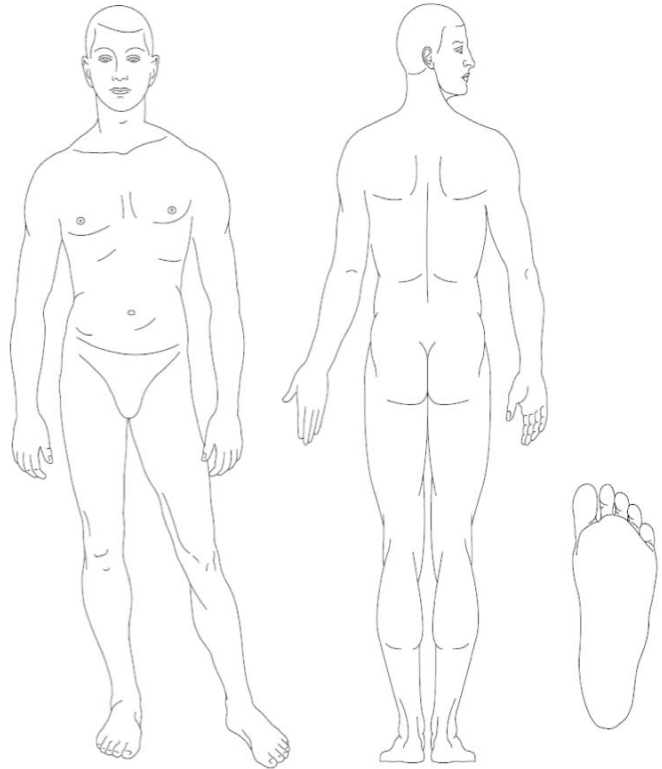
17. Medications / Allergies: _____

18. Any other medical condition(s) the therapist should be aware of? _____

Health History (check one box per item)

Mark areas of complaint / pain

	Yes/Current	Past	No
Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain/Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis/Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis, bursitis, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or joint disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nerve degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis/Golfer's elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Please read the following, check each box indicating you have read the following, and sign below:

- Draping will be used during the session – only the area being worked on will be uncovered. I agree to not expose myself, or make any illicit or sexually suggestive remarks or advances, otherwise the session will be immediately terminated, and I will be liable for payment of the scheduled appointment.
- Clients under the age of 18 must be accompanied by a parent or legal guardian (must provide documentation) during the entire session. If the client is a minor (under age of 18), a parent or legal guardian must sign the consent stated within this Client Intake Form.
- I understand that the massage/bodywork, corrective exercise, or orthopedic assessments I receive is provided for the basic purpose of relaxation, relief of muscular tension, postural balance, and to reduce physical and mental discomfort.
- If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork, corrective exercise, and orthopedic assessments should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.
- I understand that Massage Practitioners or Corrective Exercise Specialists are not qualified to diagnose, or prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
- Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Signature of Client _____ Date _____

I, _____ (Parent/Legal Guardian), hereby give my consent for _____ (specified treatment) to _____ (minor), on this _____ (date).

Signature of Parent/Legal Guardian _____ Date _____